

# WORKING WITH RESISTANCE<sup>1</sup>

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*“Man is mortal. That may be; but let us die resisting; and if our lot is complete annihilation, let us not behave in such a way that it seems justice!”*

—Albert Camus

## THE GOOD AND EVIL OF RESISTANCE

Throughout history, resistance against oppression has earned respect because human beings want to live in dignity and thus feel a kinship with others who refuse to succumb to unjust authority. Recently, the rebellion of Tibetan monks against armed occupation forces and the portrait of a lone Chinese student blocking the path of a tank near Tienamen Square continue to exemplify such acts of courageous defiance. At the root of all resistance is an attempt to maintain one's dignity in the face of a perceived threat to that dignity. *It is in this regard that all manifestations of resistance, whether in the political arena or in the therapy office, are basically similar.*

Although all resistance is similar in nature, the resistance of a patient against the efforts of the therapist is not usually viewed quite so nobly as other kinds of resistance. Resistance in a therapy patient is viewed as the sum total of those forces that “oppose the procedures and processes of treatment” (Greenson, 1967, p. 26). As Freud stated, “Whatever interrupts the progress of analytic work is a resistance” (1974, p. 517). Accordingly, the resistant patient is typically portrayed as actively “blocking” therapy progress, and the therapist's role is to help him<sup>2</sup> overcome this blockage so that treatment can continue to move along cooperatively. This “analysis of resistance” has become a cornerstone of the psychoanalytic approach (Greenson, 1967). In supervising therapists, I am constantly

hearing that the patient's resistance against the therapist's efforts is a source of confusion and concern.

Why do we approve of so many other kinds of resistance and yet view the resistance of patients disparagingly? Part of the explanation lies in our tendency to place certain value judgements on what we see and hear. We think something is "good" resistance if the thing resisted is "bad," and "bad" resistance if the thing resisted is "good."

As therapists, we believe we are good since our intentions are to help and heal our patients. However, consider for a moment that officials of the Chinese government most assuredly believed that they were acting in the spirit of goodness—and in the best interest of China—when violently ending the student demonstrations. If we view the Chinese students as noble in their cause, then we would tend to view the Chinese government as evil in its suppression. Similarly, if the patient is justified in resisting the therapist, does it then follow that we view the therapist as unjust? Or, are therapists justified in combating resistance for the good of the patient? In either case, we are making certain value judgements that can make it more difficult to heal the patient.

For therapy to proceed in a healing manner when confronted with resistance, it is most helpful if the therapist takes a position that incorporates both sides of the matter. As Pascal said, "A man does not show his greatness by being at one extremity, but rather by touching both at once" (Camus, 1960, p. 1). This is precisely our task as therapists. Viewing situations from this "middle position" increases the probability that events will flow smoothly and naturally and is consistent with the teachings of Buddhism (Kalupahana, 1987); while conversely, a one-sided viewpoint may lead to straying out of touch with immediate experience. An approach toward understanding and working with resistance that takes this middle position will be discussed.

### THE PARABLE OF THE PHYSICIAN

In Mahayana Buddhist teachings the "parable of the physician" (Burt, 1982) illustrates how resistance can arise, and how one can

respond to it helpfully. In the first part of the parable, a physician leaves his many sons and embarks upon a journey. While he is gone, his sons drink some medicine and are all poisoned. By the time the physician returns, some of his sons have lost their senses (since the poison infiltrated deeply into their systems), while other sons have not yet reached that point. When the sensible sons ask for an antidote, their father provides it and they are healed. However, the sons who have lost their senses from the poison refuse to take the antidote and become gravely ill.

This part of the parable explains how resistance comes about. When the "poisons of life" have penetrated so deeply into a person's system that his senses are distorted, he may not be able to identify help when it is offered. Such is often the case with a resistant patient. This person is so poisoned that he cannot comprehend the compassion of the healer and may instead act defensively. It is useful for the healer to view resistance less as a reflection on his own goodness, than as a result of poison. However, this understanding may not eliminate certain unpleasant responses in the therapist, such as feelings of helplessness, badness, failure, hurt, or frustration. If such feelings arise, it is best to tolerate them silently, since overt expression could lead to an adversarial rather than a healing relationship.

In the second part of the parable, the physician tells his resistant sons that he will leave a bottle of antidote with them. He adds that if they drink it, they will get well. Then he leaves. After awhile, he sends a messenger to his house and instructs him to announce that the physician has died during his journey. Upon hearing of their father's death, the resistant sons regain their senses, take the antidote, and get well.

The clever physician thus led his resistant sons to believe that there was no one left to resist. When resistance is not met by counterforce it becomes unnecessary. Such is the method I recommend in working *with*, not against, resistance.

Fromm-Reichmann (1950) beautifully illustrates this point when she describes the treatment of a catatonic woman by a dedicated clinician. After remaining mute for a long period of time despite the therapist's repeated attempts to gain her interest, the patient blurted

out “I don’t know why you continue trying. Don’t you see that I am not interested?” (p. 110). The therapist responded by further trying to encourage the patient, to which the patient responded with further mute resistance. As in the parable of the physician, the therapist finally responded in such a way that there was nothing against which to resist. He said that “he had no personal stake in the question of the patient’s recovery other than the legitimate interest of fulfilling the professional obligations and responsibilities incurred when accepting the job of doing psychotherapy with the patient...even if his efforts were destined to fail because the patient’s interest could not be aroused” (p. 111). The patient immediately looked more relaxed and, in the following session, communicated more freely. Later in the therapy, the patient explained that she would cooperate only after she felt that no debt would be incurred by accepting treatment.

While the parable illustrates a model of working with resistance, the Fromm-Reichmann example further suggests that following this model helps the patient to preserve his dignity. It is interesting to note that the efforts of the therapist to impose help upon the patient actually kept the resistance in place. It was only when the therapist behaved more respectfully toward the resistance and no longer expressed an interest in removing it, that the patient could relinquish his resistance.

## RESPECTING RESISTANCE

By viewing resistance as an obstacle to be removed, instead of respecting resistance as most of us would respect an insurrection against tyranny, we strengthen the patient’s need to defend himself. When a patient resists, it may be because he feels that a threat to maintaining his dignity and integrity is looming ahead in the therapy process. Therefore, if we respect resistance as an attempt to preserve dignity, the patient will sense this respect and there will be no need for resistance.

For example, one of my patients had an extremely strong resistance to crying in her early sessions, explaining that crying embarrassed her because it made her “feel like a baby.” She reported

feelings of self-hatred whenever she lost control of her emotions, and this was not ameliorated by therapeutic assurances that there was nothing wrong with having or expressing feelings in the sessions. This patient changed the subject, or paused, if she thought that continuing to talk might make her cry. By allowing her to avoid these instances of emotionality without commentary from me, the therapy supported her in maintaining and building her dignity. And, much later in treatment, she was able to express her feelings without any trauma. To have "interpreted" such avoidant behavior to the patient as an uncooperative resistance would only have added insult to injury. If the therapist understands, allows, and works along with the resistance, this can lead to health.

Silence is often seen as resistance. Therapists and patients alike share the impression that periods of silence represent a problem, or resistance, of some sort. For example, one of my patients was frequently silent for large portions of his sessions, sometimes spending half of a session in silence. Early in his treatment I inquired about what kept him so silent and in response he became even more silent. Later he informed me that he felt that my inquiry was an admonishment; it made him feel as if he were wasting my time. He indicated that he might be able to talk more if I asked him more questions. I cooperated but he found that this approach failed to alter the situation.

Further on in his therapy, the patient revealed that his father was a very demanding and stern man who had little tolerance for children. For instance, when the patient was a child, his father took him hiking in the woods. Although the boy quickly tired and fell behind, his father did not slacken his pace and seemed exasperated with his son's inability to keep up. Understandably, this patient continually set unreasonably high goals for himself and was very harsh with himself if he could not live up to them. Talking in therapy was no exception; he expected himself to be loquacious in the sessions and to maintain a certain pace. When he failed to do so, he felt depressed and even less able to talk. His resentment over feeling "forced" to maintain an uncomfortable pace thus made him feel resistant to talking.

I told this patient it was not necessary that he talk so much, and

that he could be silent for as long as he needed. I added that I did not mind sitting quietly with him when he was silent and that whenever he felt able to talk again, I would still be ready to listen to him. Over the months since this intervention, the patient has gradually increased his amount of talking and seems more comfortable with himself both in sessions and in his life. Soon after working with his "resistance" in this manner, the patient began to confront issues of workaholism and unrealistic expectations for himself on his job.

Omission of certain subjects is also likely to be seen as resistance. If a patient does not talk about those subjects therapists normally hear, we might consider it resistance. For instance, a seriously depressed woman entered treatment with me because of career difficulties and turbulent relationship problems. During the time she spent in therapy, this patient overcame her depression, completed her unfinished graduate degree, became a well-respected manager in a large corporation, and met and married another executive. Presently, she is content with herself and her life, and looking forward to new job challenges as well as having a child someday soon. She accomplished all of this while hardly ever mentioning her past history.

This patient simply talked about the current events of her life. Early in her treatment, I wondered out loud about why I never heard her talk about her childhood. She responded that she "didn't usually think about her childhood." Since her progress was excellent, it was not necessary to delve any further. Except for one or two sessions regarding high school memories, the patient had a rather thorough resistance to speaking about her past. Yet, it obviously did not interfere with her progress in therapy.

A person's natural tendency to be cautious when entering a new situation also applies to therapy. Hillman (1964) points out that the hesitant patient is neither trying to hide information nor be uncooperative, but instead feels obliged to withhold certain material until "he feels that the bond between him and the analyst is not a programmatic condition imposed by the rule of a profession, but is a real connection" (p. 177). And even then, this connection is usually a gradually deepening process rather than an instant phenom-

anon. Nevertheless, patients in treatment often believe that they should feel some kind of instantaneous trust in the therapist and may identify their own reluctance as resistance.

An example of this pressure to trust was apparent in a patient who entered therapy with me after experiencing difficulties in her last therapy. Apparently her previous therapist was in very poor control of himself and a sexual relationship ensued. It was with great effort that the patient was able to pull away from this treatment and begin speaking with me. The patient frequently wondered whether I was the "right therapist for her," since she did not immediately experience the trust that she had hoped to feel for a therapist. It had not occurred to her that she had good reasons for mistrust and that it might be natural, under the circumstances, to mistrust any therapist. I explained this to her and told her that trust is not a prerequisite for therapy progress. Indeed, her mistrust lasted for many months, yet she progressed nicely during that time.

An accepting attitude toward mistrust is consistent with the Vajrayana path of Buddhist study wherein the beginning student is encouraged to "intelligently decide, 'Is this teacher for me?'" (Kalu, 1986, p. 69). Regarding the early stages of involvement with a spiritual teacher, the XIVth Dalai Lama states:

At first it is much better if one does not have that kind of [trusting] attitude toward [the teacher]; simply regard him as a Dharma-friend. One gets teachings, and time goes by. Then one feels that one knows the person quite well and can take them as one's guru without any danger of transgressing the commitments that accompany such a relationship. When one has that kind of confidence, then one can go ahead and take him on...(Gyatso, 1988, p. 66).

If we allow ourselves to be the recipients of mistrust, or other forms of resistance, without feeling that we must change things, the patient can experience his own resistance as the beginning of a validating and healing process. According to Spontnitz (1985), "when a therapist remains open to the patient's disagreeable feelings and retains the capacity to understand and communicate..." (p. 244), the patient can have a healing experience. On the other hand, patients who are confronted with the idea that they are "resisting" because of poor mental health or inaccurate perceptions are essen-

tially being told that they are misguided in trying to stand up for themselves in the context of therapy. This communication is often confusingly coupled with the message that it is good to assert themselves elsewhere.

## RESISTANCE IN SUPERVISION

Most of the problems presented in supervision relate to some discrepancy between what the therapist believes should be happening and what is actually happening in the therapy. The therapists I have supervised have been very devoted and committed to helping their patients. However, because there is a fine line between compassion and its "near enemy," pity, there is always the danger of confusing the two (Kornfield, 1988, p. 24). This can spur a therapist to impose more "help" than is actually helpful. Lucas (1986) sees this kind of help as "pulling the patient into health while the patient is dragging his feet against the road."

If the therapist is attached to the idea of fulfilling certain goals with the patient, and the patient resists this idea, the continued "grasping" (Kalupahana, 1987, p. 84) for these goals on the part of the therapist can lead to more problems. The therapist who desperately tries to protect a patient from repeating painful self-defeating patterns, may find himself frustrated, and may inadvertently strengthen the patient's resistance to progressing beyond these patterns. In Buddhist psychology such grasping is seen as the root of suffering and is frequently at the root of problems brought to supervision sessions.

Supervision involves considering the twofold welfare of the therapist and that therapist's patient. It is another instance where taking the middle position helps transcend the tendency to take sides and allows the supervisor to fully consider the welfare of both parties in the therapy relationship. In Buddhist psychology, the middle position is referred to as considering the "true welfare," *sad-attha*, of a situation (Kalupahana, 1987, p. 51). If the supervisor does not take this middle position and, for instance, takes the welfare of the



patient as foremost, the therapist may be alienated and is more likely to "resist" supervision. Conversely, if the supervisor sides with the therapist, that therapist's patient might become alienated.

For example, a supervisee reported that only one of her cases was giving her immense trouble. Her "troublesome" patient was a man who had very low self-esteem, extreme fears of intimacy, and an inability to form relationships. She reported that her patient constantly presented evidence that he was a failure as a human being, that he was beyond help, and that the therapy was not working. When he would deprecate himself in sessions, the therapist would feel an increased urge to help him and a strong wish for the patient's suffering to relent. It was clear that she felt a good deal of affection and compassion for this patient.

The therapist reported that the patient was resisting therapy by spending most of his session obsessively discussing minute details of situations, conversations, and physical ailments in a non-emotional manner. When she pointed this out, he admitted that he obsessed much of the time and that other people have told him how annoying they found it. Nevertheless, he was unable to control it. The therapist felt that she was failing with this patient and that she should stop him from obsessing.

While there is nothing inherently anti-therapeutic about allowing the patient freedom to obsess in this manner for as long as he needs, and while I might have explained this to a more advanced supervisee, it posed a problem for this particular therapist who had a strong desire to feel active and effective. In light of the needs of both my supervisee and her patient, I suggested that she occasionally ask her patient for even more explicit detail than he was already providing. Spontitz (1985) discusses similar interventions in his explanation of "joining" techniques, wherein the therapist reflects the patient's communication style. Under the circumstances, my supervisee found this suggestion intriguing and looked forward to trying it in the next session.

As in the parable of the physician, the intervention is designed to open up a space within which the therapist can move more freely

and comfortably and thereby allow the patient to do so as well. Requesting a bit more of what she was already getting might relieve the tug-of-war on this issue in treatment. The therapist gives the patient a message that his resistant maneuvers are acceptable to the therapist, and that he can continue these if he so needs. Concurrently, the therapist can feel that she is actively participating and that she and the patient are moving in the same direction. Thus, she no longer has to feel ineffectual.

After her next session with this patient, the therapist reported that, since she was initiating the request for details, she found herself much less irritated by the patient's obsessing. She humorously remarked, "How can I complain when I was kind of asking for it?" And after the following session she reported, "Today was the easiest session I've ever had with him. Out of the blue, he started to talk about his fear of change and his fear of getting close. But he realized that he had to work harder to get over his problems so he can have relationships. He actually did some real work!"

Supervising a therapist regarding a problematic case does not simply involve providing an intervention that the therapist can repeat to the patient, although this is often helpful. Central to the supervision process is teaching a way of being which, by its very nature, will remove the need for resistance. Supervisory suggestions are most likely to be helpful if they carefully preserve the dignity of both therapist and patient. This is the middle path. In conducting supervision, the supervisor helps both the therapist and patient to follow this path in their sessions together.

## THE ILLUSION OF RESISTANCE

Each time that resistance seems to appear, the therapist's contemplative re-evaluation of the therapy situation is usually adequate to lead to the disappearance of that resistance. Resistance vanishes when the therapist achieves a clear experience of the "resistant" behavior and can view it as the patient's attempt to maintain his dignity against a perceived threat, or merely as part of the patient's

style of communication. It is in this sense that resistance is an illusion that can distract us from a complete and immediate experience of the patient. Moreover, the perception of resistance can impede the healing process, since it places the therapist in an adversarial relationship with the patient.

Buddha maintained that even good things, let alone bad things, should be abandoned (Kalupahana, 1987, p. 50-51). Certainly the desire to see the patient make progress and the desire to relieve the patient's suffering represent good and compassionate goals. However, if we perceive resistance in the patient, this may mean that "grasping" for these goals has become a distraction from the immediate experience of the therapy session. According to Lucas (1986), when Freud originally named the phenomenon of "resistance," he selected that name "because he had the feeling that the patient was resisting, and not cooperating with, his treatment plan." Implicit in identifying resistance is a value judgment that the path upon which the therapist wants to proceed is better than the path that the patient selects.

The shared journey upon which patient and therapist set out is meant to bring the patient to health. The patient may not be able to take as direct a route as the therapist would like, and those activities that are identified as resistances may be necessary detours on this journey. The moment that resistance is identified is thus critical. It is at this juncture that the patient and therapist either continue together or separate along different paths. Since the patient is generally trying his best to pursue a route to health in his work with the therapist, it would be a blow to the patient's dignity to treat these sincere efforts as wrong-minded or "resistant." Such treatment might strengthen the patient's defensive efforts to preserve his dignity and thereby lead to interactions that reinforce the perception that the patient is resisting the therapist's help.

In grappling with the illusion of resistance, the therapist may lose touch with selflessness and spaciousness—the qualities which are the foundation of therapeutic healing can vanish. Seeing resistance in a patient attributes a quality to the patient as well as implies

a quality of the therapist. We are saying to the patient that this resistance is “yours” and it belongs to you alone; or else the problem I am having with the resistance is “mine” and belongs to only me. The natural and mutual flow of the therapy process then becomes bifurcated into “your process” and “my process.”

What accounts for this manner of thinking? I believe that it is “irritation.” The therapist may become irritated if he perceives the patient to be resistant to the help, insight, or progress that might otherwise relieve that patient’s suffering. Once such irritation arises, the therapist’s experience of the spacious flow of the treatment might then become changed. Trungpa (1973) points out that, “Whenever irritation is involved, then we are not able to see properly and fully and clearly the spacious quality of all which is coming toward us, that which is presenting itself as communication” (p. 171).

What one therapist might view as resistance another might simply consider to be part of the patient’s style of communication. When the therapist is more malleable, there is less to resist, less to be seen as resistance, and less to engender irritation. According to Buddhist psychology, “having achieved such flexibility, one can proceed to have an understanding of the experiential process” (Kalupahana, 1987, p. 47). There is no resistance if we are truly open.

For masters of the way, “their actions are their presence, their mindfulness, their own personalities. This non-action, this awakened presence is their most fundamental contribution” (Sivaraksa, 1988, p. 11). As therapists, our most important contribution to the healing of the patient is our ability to “resonate” (Silverberg, 1988) with and “be with” the patient in a truly accepting way. Given the great emphasis that the psychotherapy profession (and our society at large) places upon the use of techniques and strategies, it is easy to be influenced into thinking that if only we apply these techniques or those others, then the patient will be healed. It is important that therapists not be misled in this way, and additionally important that therapists keep in mind that the patient will follow his own path to health as long as a healing emotional environment

is provided. We can help to provide this environment with our presence, our openness and our mindfulness.

When we can accept the patient's "resistances" for what they are—an expression of that person at that moment attempting to present himself with dignity in the ongoing process of relating—then there is no resistance. If we realize that there is no resistance, then there will be no drive to impel us to take action to change things, and the natural process can continue to unfold toward the path of health for the patient. It is useful to remember that "to act in a way that arises from non-action is to act in a way that truly influences the situation" (Sivaraksa, 1988, p.11). Let this be our goal as therapists.

#### NOTES

1. I am indebted to Dr. Gerald Lucas, Mr. Robert Walker, and Ms. Heather Winett for the interesting dialogues that helped me to clarify certain points in this article.
2. In order to avoid awkward "him/her" phrasing, the convention of using he, him, and his in this article will be used to represent all individuals.

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